STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	11/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00098288, IN00098714, IN00098526, and IN00099272. This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 10-7-11. This visit included the PSR to the complaint IN00096702 completed on 10-7-11. This visit was in conjunction with the PSR to the Investigation of Complaints IN00094814, IN00095455, IN00096396,IN00096640 completed on 9-16 -11. Complaint Numbers: IN00098714- Substantiated, a Federal/State deficiency related to the allegations is cited at F224 IN00098288-Unsubstantiated, due to lack of evidence. IN00098526-Unsubstantiated, due to lack of evidence. IN00099272-Unsubstantiated,due to lack of evidence. Survey Dates: November 7,8,9,10,13, &	F0000	Submission of this Plan of correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	11/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	14, 2011 Facility # 000032 Provider #155077 AIM Number #100273330 Survey Team: Patti Allen, BSW, TC Elizabeth Kolasa, RN (November 7,8,9,10, 2011) Leia Alley, RN (November 7,8,9,10, 2011) Courtney Mujic, RN (November 7,8,9,10, 2011) Kim Perigo, RN (November 7,9,10, 2011) Census Bed Type: SNF: 23 SNF/NF: 120 _____ Total: 143 Census Payor Type: Medicare : 23 Medicaid : 99 Other: 21 _____ Total: 143 Sample size: 14 This deficiency also reflects State findings cited in accordance with 410 IAC 16.2.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	11/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed on November 21, 2011 by Bev Faulkner, RN			
F0224 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure a bedpan was removed from underneath a resident during the night time hours, resulting in a sore buttock area. This involved 1 of 3 residents reviewed for an allegation of neglect in a sample of 14. Resident CC. Findings include: The clinical record for Resident CC was reviewed on 11/7/11 at 11:50 a.m. Diagnoses for Resident CC included but are not limited to breast cancer, ovarian cancer, paraneoplastic syndrome (an immune disorder that affects the central nervous system in response to cancer in the body). A review of an MDS (Minimal Data Set) on 11/7/11 at 2:00 p.m. indicated Resident CC received a score of 15 out of 15 possible points, indicating she was cognitively intact with no impairment.	F0224	I. As clarification, please note that the incident alleged to have occurred on 10/3/11 was not reported by the resident until 10/10/11, at which time an investigation was initiated in regard to the resident's concern. The incident was fully investigated, with involved caregivers interviewed and re-educated. Following said investigation and corrective actions taken, the resident was informed of the resolution and inquiry made as to whether the resident would like to schedule a healthcare conference to discuss this (or any other) concern(s). The resident stated that it was not necessary; she was very comfortable in the facility and did not feel as if she was intentionally	11/28/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	11/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 11/7/11 at 11:50 a.m., Resident CC indicated she was left on a bed pan for the entire evening shift and it left "a big red ring" on her "butt." She indicated that this was the night she returned to the facility after being at the hospital for treatment, but was not exactly sure of the date. She indicated that once she put on her call light and a CNA (Certified Nursing Assistant) that answered her, indicated that she was not her aide and would find her aide to come and help her. Resident CC indicated no one came to help so she put the call light on again and a different CNA indicated she would come back and didn't. Resident CC indicated she was left on the bed pan all night, the night she returned from the hospital for treatments. The clinical record indicated the resident returned on 10/3/11 and according to the resident the incident would have occurred on the date of 10/3/11 in the evening and into the morning hours of 10/4/11. During a confidential interview with an acquaintance of Resident CC on 11/9/11 at 12:00 p.m., the acquaintance indicated they had found Resident CC on the bed pan when they had visited with the resident and was "infuriated" when the resident said she had been lying on the bed pan all night.		mistreated. The resident stated she did not want to discuss the matter further and remained content in the facility. II. In an effort to identify any other resident with a concern in regard to care/treatment/alleged neglect, the facility has initiated daily interviews with residents of the facility identified as "interviewable". Said interviews are occurring 5 days per week with random interviews occurring over the weekend. Administrative staff of the facility are ensuring that any concerns voiced by a resident and/or family member are appropriately investigated with corrective actions initiated immediately, as warranted. III. As a means to ensure ongoing compliance with the prohibition of mistreatment, neglect, abuse and misappropriation of resident property as well as consistent implementation of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	11/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A "Skin Condition Flowsheet for Non-Pressure Related Skin Conditions," dated 10/3/11, was reviewed on 11/8/11 and indicated the resident was admitted with a "reddened area around anus" which was "0.1 x 0.1" cm in size. Another flowsheet, dated for 10/6/11, indicated resident had "0.2 x.2 x 2" "blisters" on buttocks that was "acquired after admission." During an interview with the DON on 11/10/11 at 10:30 a.m., she indicated that the skin flowsheet from 10/6/11 was incorrect and that the nurse that did the assessment was unaware that the area on her buttocks was already there from her re-admission on 10/3/11, and indicated there was a "late entry" on the form from the nurse explaining it was there when Resident CC admitted and was not new as of 10/6/11. A facility policy, undated and titled "Abuse Prohibition, Reporting and Investigation Policy and Procedure" indicated "Neglect is the failure to provide goods and services necessary to avoid physical harm, mental and/or physical anguish or mental illness." It also indicates that "the facility Administrator is designated as the individual responsible for coordinating all		corresponding policies and procedures, nursing staff have received inservice training in regard to timely response to the resident call lights, provision of timely assistance with bedpan/toileting needs, as well as the various types of abuse and examples of care considered to be mistreatment, neglect and/or abuse of residents. Following the aforementioned inservice training, the facility has initiated interviews with residents of the facility identified as “interviewable” at least twice weekly. Said interviews are occurring at least twice weekly with random interviews occurring over the weekend. Additionally, administrative nursing staff shall conduct routine observations of those residents identified as requiring use of the bedpan for toileting needs during scheduled days of work to ensure timely removal of the bedpan. Should non-compliance with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	11/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	efforts in investigation of abuse allegations and for assuring that all policies and procedures are followed." A request for the facility investigation on Resident CC's issue in regards to being left on a bed pan was requested on 11/9/11 at 2:40 p.m. Two facility "Report of Concern" documents dated 10/10/11 at 7 p.m., and 10/11/11 at 3:00 p.m., were reviewed on 11/9/11 at 2:00 p.m. The reports indicated Resident CC reported to an LPN on 10/10/11 that she was on the bed pan "all night." The report on 10/11/11 indicated Resident CC told a person from Social Services the same issue, then again to the Unit Manager on 10/12/11. Two CNA's were interviewed on 10/12/11, one indicated she stayed with the resident while she was on the bed pan and one CNA indicated she doesn't remember if she worked the hall the resident resided on. This federal tag relates to Complaint IN000098714. 3.1-28(a)		provision of timely assistance be identified, immediate corrective action shall be taken, including re-education and disciplinary action, if warranted. IV. As a means of quality assurance, the administrator will review record of interviews conducted twice weekly on scheduled days of work to confirm continued identification of resident concern(s), initiation of investigation, as warranted, and corrective measures taken in accordance with facility policies and procedures prohibiting mistreatment, neglect, abuse and misappropriation of resident property. The administrator shall also review administrative nursing observations of those residents requiring the bedpan for toileting to ensure timely assistance continues to be provided. Results of the aforementioned interviews,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	11/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			administrative nursing observations, and subsequent actions taken, shall be provided to the quality assurance committee on a quarterly basis for review and revision of frequency of interviews and observations, as warranted.	